

RELATIONSHIP QUALITY IN GERIATRIC HEALTHCARE DELIVERY: A SUSTAINABLE MODEL

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ABSTRACT

OBJECTIVE:

This study is undertaken to examine geriatric relationship quality in healthcare delivery in Kerala. Drawing the hypothetical relationship, a model for elderly geriatric healthcare delivery to be developed.

METHODS:

This is a cross-sectional study. Structural Equation Modelling (SEM) technique, based on a positivist approach, was employed to analyse the association between relationship quality and geriatric healthcare delivery. The data was collected from 405 elderly people in Kerala, using a survey questionnaire, between June 2020 and November 2020 adopting multi-stage sampling. The latent constructs used for the study were service quality, relationship quality and patient centricity.

RESULTS:

A consistent empirical model of predictive relationships between the hypothesized variables was found, and a geriatric relationship quality healthcare model was developed. It is found that service quality, relationship quality and patient centricity are highly significant in elderly healthcare delivery. Service quality has emerged as a significant determinant of relationship quality. Even though patient centricity is not hypothetically related to relationship quality, it is a significant determinant of service quality.

CONCLUSION:

Geriatric healthcare management must consider relationship quality as a prominent factor while evaluating the quality of healthcare delivery as it includes the outcome of all the structural and procedural aspects.

KEYWORDS

Relationship Quality, Geriatric Care, Satisfaction, Service Quality, Patient Centricity.

INTRODUCTION

In the globalized era, the concept of relationship is very significant in both service and manufacturing industries. It has been conceived as both an outcome and predictor construct. Having perceived as a significant determinant in the customer decision-making process and new product development, relationship quality has also captured the marketers' attention more than ever before.

Relationship quality is an outcome, formed by the interaction between the service provider and the consumer, where the latter derives a positive affective outcome from the relationship and the former, primarily, gets the competitive advantage out of it. However, there is a lack of consensus on the definitions of relationship quality construct. The most widely discussed definition of relationship quality is given by Palmatier et al. [1], which refers to the whole assessment of a relationship's strength. Essentially, the evaluations of the services received by the consumer, the service providers' mentality and attitudes, personal and non-personal communication, service delivery, hospitable, empathetic, and courteous behaviour, and the 'give and take' attitude determine this multi-dimensional construct.

Relationship quality has been widely discussed in the literature in many contexts.[2] Internationally, building and maintaining quality geriatric healthcare facilities have become one of the most important agendas for providing universal health care access to the elderly under the umbrella of Sustainable and Millennium Development Goals (SMDGs). Health conditions worsen when age increases, and consequently, give rise to many psychological, physical, and behavioural issues and disabilities, contagious infections, and chronic diseases. In turn, during the higher healthcare episodes, they go through varied experiences, leaving either impact on their increased wellbeing or negligence, leading to worsened health. To sum up, relationship quality is a significant determinant of health care seeking behaviour where the absence of this may lead to delayed or denied healthcare access.

The measures which encompass the relationship quality construct are inconsistent with the previous studies. Despite having an array of studies on geriatric care, very few studies focus on quality geriatric healthcare delivery and its consequence in fostering relationship quality. To date,

there is insufficient evidence that brought out the effect of patient centricity and service quality in enhancing relationship quality in healthcare delivery, particularly among the elderly population. Also, to the best of knowledge, there is no research conducted on geriatric relationship quality dimensions in healthcare delivery in Kerala context, particularly when the Kerala healthcare model has gained global acclaim in preventing the Nipah outbreak in 2018 and COVID-9 pandemic. Thus, this study fills the above gaps by investigating the association between relationship quality with service quality and patient centricity constructs, developing a sustainable geriatric relationship quality model. This study is significant wherein Kerala is the fastest ageing state in India, where about 20 percent of the total population is elderly.[3] This research can help the healthcare facilities to recognize the significant relationship quality variables and focus on effective geriatric care management.

METHODS

This research is based on a positivist paradigm. The data was collected by means of a structured questionnaire from 405 elderly persons in Kerala using a multi-stage sampling technique. The study area was divided into three zones, south zone, central zone and north zone. From each of the zones mentioned above, three districts had been selected randomly. Four panchayats (local self-institutions) from each of these nine districts were selected by drawing lots, making 36 panchayats under study. From each selected panchayat, 11 households with elderly persons were randomly selected. The elderly who received healthcare services from any hospital in Kerala from June 2020 to November 2020 were the study participants. The respondents to the survey questionnaire included any of the resident members above the age of 60, who could respond to the questionnaire. When there were two older adults in one household, it included only one person in the study. The survey questionnaire was filled by the participants themselves except in the case of bedridden elderly.

The study designed a survey tool to collect data. It included two sections. The first section sought demographic information on age, gender, educational level, marital status, employment status, and the reason for hospital selection. Second section included 20 items to assess the relationship quality, patient centricity, and service quality constructs, measured in 5 points Likert scale. The tool was

designed by adapting important models, frameworks, and studies in the related areas. Five dimensions of the SERVQUAL model (Tangibility, Reliability, Responsiveness, Assurance, and Empathy) [6,7,8,10] and structure-process-outcome (SPO) model of Donabedian [22], medical tourism model [10] important previous studies on relationship quality [2,4,5] and patient centricity [7,9,10,23] are imbibed in the chosen constructs. Service quality construct included 12 variables under five domains, relationship quality included five variables under trust and satisfaction constructs and patient centricity included three variables. The validity of the questionnaire was evaluated based on content validity and experts' opinion. A pilot study was conducted, using a survey of 30 participants to make sure that items in the survey questionnaire were correctly interpreted. From the 20 items in the second section of the questionnaire, two questions were omitted, in which respondents generally did not respond and added two more questions relevant to elicit information on the chosen constructs. Reliability test scores of all the constructs were above the guideline value. Service Quality ((Tangibility ($\alpha=.801$), Assurance ($\alpha=.734$), Reliability ($\alpha=.675$), Responsiveness ($\alpha=.716$), Empathy ($\alpha=.724$)), Patient Centeredness ($\alpha=.807$) and Relationship Quality (Trust ($\alpha=.730$) and Satisfaction ($\alpha=.725$)).

The survey instrument was originally designed in English and then translated to the local language, Malayalam for better understanding. Each respondent in the study was briefed about the study, and informed consent was obtained. COVID-19 protocol was adhered during the data collection process. The study was carried out as per the guidelines and permission of Indian Council of Social Science (ICSSR), New Delhi.

Descriptive analysis was performed on baseline characteristics, including age, gender, income, marital status, and education with SPSS 2.0. After the process of data screening, a Confirmatory Factor Analysis (CFA) was done using Amos (Version 20.0) to validate the structure of observed constructs to recognize the relationships among the constructs of relationship quality (satisfaction and trust), service quality, and patient centricity. A Structural Equation Modelling (SEM) technique was considered to analyse the

relationship between relationship quality and elderly healthcare delivery dimensions.

MEASURES AND CONSTRUCTS

This study developed three primary latent constructs based on literature review and perusal of various related models, such as relationship quality, patient centricity, and service quality. The relationship quality construct was conceived as a composite construct (independent variables) with different interpersonal outcomes of a successful relationship. The most widely accepted aspects of relationship quality are 'satisfaction, trust, and commitment' and hence the study included these three latent constructs wherein 'trust' construct measured 'commitment' as well, to reduce the latent constructs into two with five variables. [2,4,5] Service quality construct in healthcare delivery is measured by using the five dimensions (Table 1) of the SERVQUAL model. [6] Overarching these five dimensions, the construct was measured using 12 variables (Table 1), adapted from earlier studies, suitable to the study context (7, 8). Patient centricity is a complex construct determined by the quality of interpersonal communication between the caregivers and patients wherein an empathetic listening, provision of diagnostic information in patient's language, and spending enough time to answer queries and addressing their worries are imbibed. Cooper et al. [9], perceived the construct through the outcome variables like rapport and patient satisfaction. Empathetic communication and sharing of information on the diagnostic and aftercare aspects are integral factors linked to patient satisfaction. The construct was measured using three variables (Table 1). To address the study objectives, two hypotheses were proposed.

H1: Service quality enhances relationship quality in geriatric healthcare delivery.

H2: Patient-centricity enhances relationship quality.

TABLE1. MEASUREMENT ITEMS

SERVICE QUALITY	RESEARCHER(S)
1) Tangibles: physical facilities, equipment	(6, 8, 10)
2) Reliability: ability to deliver the promised service and privacy of care	
3) Responsiveness: willingness to help, and provide prompt service, waiting time for accessing healthcare	
4) Assurance: knowledge/expertise of the doctor and staff, courtesy of hospital staff	
5) Empathy: personal care, understanding the elderly.	
RELATIONSHIP QUALITY	
Trust Willingness to rely on the hospital again.	(11,12)
Confidence in the hospital services.	(12,13)
Emotional attachment with the hospital.	(5,12)
Satisfaction Overall Satisfaction	(10-12,14)
Meeting expectations.	(10,12)
PATIENT CENTEREDNESS	
Spending enough time to listen concerns	(10,14)
Provision of timely information	(9,10,14,15)
Answers all my questions	(10,14)

RESULTS

SOCIO-CULTURAL VARIABLES

The survey was conducted among 405 older adults in Kerala of which 55.3% were males, and 44.7% were females. Around 50.1% of them were in the 60-69 age category, 31.6% belonged to 70 -79 category, 14.8% belonged to 80-89 category, and 2.2% were above 90 years of age. 77.5% were married, 2.7% were not married, 18.5%

lost their life partners, and 0.7% divorced their life partners. The educational status of the elderly showed that 18.3% do not have any formal education, and a large majority (65.9%) has school education and 13.1% has higher education from colleges and universities.

Regarding the mean score of constructs, all variables received a high average score >4 except for 'waiting time,' and 'promptness in service' under the Responsiveness dimension of Service Quality construct (Table 2).

TABLE 2. MEAN VALUES OF THE CONSTRUCTS

CONSTRUCT	VARIABLES	MEAN	STANDARD DEVIATION
Satisfaction	Meeting Expectation	4.2938	0.87035
	Overall Satisfaction	4.3654	0.89265
Trust	Trust in services	4.3235	0.87686
	Revisit	4.3778	0.79166
	Emotional Attachment	4.2914	0.86405
Tangibility	Physical Facilities	4.2568	0.88901
	Modern Equipment	4.2617	0.90687
Assurance	Expertise of the doctor	4.4889	0.77268
	Knowledge of doctors and staff	4.4667	0.76882
	Courtesy of the staff	4.4543	0.75519
Reliability	Privacy	4.3012	0.86352
	Provides the assured service	4.3358	0.82103
Responsiveness	Willingness to help	4.4049	0.75385
	Waiting Time	3.5704	1.42054
	Promptness in service	3.7506	1.40879
Empathy	Personal Care	4.1111	0.92276
	Understanding my needs	4.2691	0.81092
Patient Centricity	Spending enough time to listen concerns	4.5062	0.65104
	Provision of timely information	4.5358	0.67621
	Answers all my questions	4.4963	0.75983

CONFIRMATORY FACTOR ANALYSIS

To achieve the research objectives, a Structural Equation Modelling (SEM) technique was adopted to evaluate the current perceived level of service quality in geriatric healthcare delivery in Kerala and its effect on satisfaction and trust. SEM is a statistical technique to evaluate the relationship between multiple variables simultaneously, consisting of statistical techniques such as regression and factor analysis. SEM consists of a two-step process. First, a confirmatory factor approach is adapted to test the relationship between variables and their constructs. Second, multiple regression techniques are adapted to test the relationship between variables to establish evidence of directionality and the significance of the relationship. The

basic assumption in the Confirmatory Factor Analysis (CFA) is that all factors are correlated. However, they are separate constructs. The high correlation of indicators is denoted as convergent validity, and the difference between each construct is denoted as discriminant validity. Ellipses represent the factors or constructs, and their indicators are represented as rectangles.

In the current research, Service Quality, Patient Centricity, Relationship Quality (Trust and Satisfaction) were considered as constructs under the study. The interrelationship between variables and indicators of constructs was evaluated using CFA. The proposed CFA model is presented in Figure 1. A construct under service

quality named 'Responsiveness' and an indicator of Assurance have been removed from the final analysis, as it has low loading with their constructs.

Various fitness indices are used to test the best of the proposed CFA. The fit indices reveal that the final CFA model, after deleting some items on the scale, is acceptable to excellent fit. The model fit of CFA is presented in Table 3.

TABLE 3. FIT MEASURES OF FINAL CFA MODEL

MEASURE	ESTIMATE	THRESHOLD	INTERPRETATION
CMIN	178.264	--	--
DF	67	--	--
CMIN/DF	2.661	Between 1 and 3	Excellent
CFI	0.960	>0.95	Excellent
GFI	0.927	>0.90	Acceptable
AGFI	0.881	0.80	Acceptable
SRMR	0.034	<0.08	Excellent
RMSEA	0.064	<0.06	Acceptable
PClose	0.021	>0.05	Acceptable

Fitness measures such as CMIN/DF, Comparative Fit Index (CFI), and Standardized Root Mean Square Residual (SRMR) show excellent fit. The fit indices like Goodness of Fit Indices (GFI), Adjusted Goodness of Fit Indices (AGFI), Root Mean Square Error Approximation (RMSEA), and the Probability of Close Fit (PClose) show the acceptable fitness. The right fitness allows the researcher to deploy structural models to test the proposed hypothetical relationship between constructs.

STRUCTURAL MODEL

SEM is developed to test the underlying relations stated in the form of a hypothesized relationship among latent variables, based on the theoretical relationship between various variables through a thorough literature review. In the current study, the relationship between service quality,

patient-centricity, trust, and satisfaction is measured using SEM. In this research, trust and satisfaction were represented through a second-order latent variable called 'Relationship Quality. Figure 2 presents the resulting structural model.

The result of the hypothesis testing (Table 4) indicates that service quality has a significant positive impact on perceived trust and satisfaction in geriatric care. However, the patient-centeredness does not contribute to the overall relationship quality. It shows that the elderly perceives that geriatric care is not most patient centric. Both the 'trust' and satisfaction together reflect relationship quality. While the 'trust' dimension explains 92 percent of the relationship quality, the 'satisfaction' explains about 73 percent of relationship quality.

FIGURE 2. STRUCTURAL MODEL

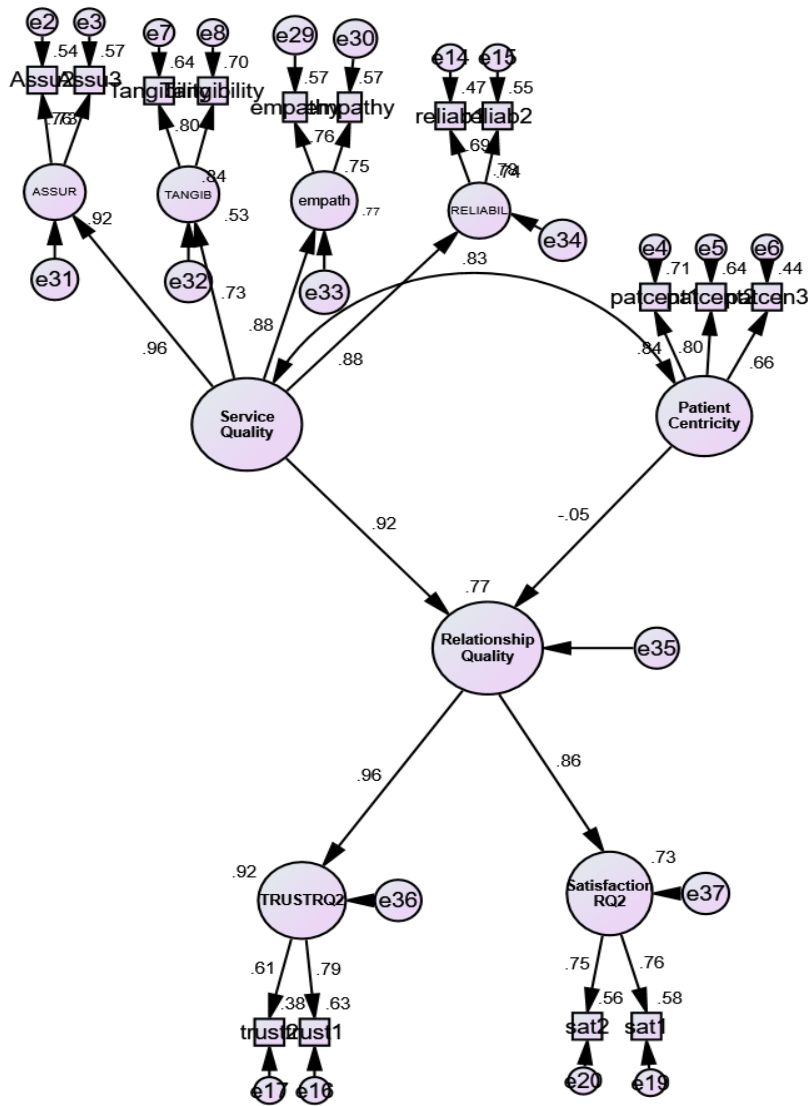


TABLE 4. RESULT OF HYPOTHESIS TESTING

INDEPENDENT VARIABLE		DEPENDENT VARIABLE	STANDARDISED B	T VALUE	SIGNIFICANCE	ACCEPT OR REJECT
Relationship Quality	←	Service Quality	0.920	6.613	0.000*	Accepted
Relationship Quality	←	Patient Centeredness	-0.051	-0.437	0.662	Rejected
Assurance	←	Service Quality	0.958	10.751	0.000*	Accepted
Tangibility	←	Service Quality	0.728	9.510	0.000*	Accepted
Reliability	←	Service Quality	0.880	11.093	0.000*	Accepted
Empathy	←	Service Quality	0.878	12.179	0.000*	Accepted
Trust	←	Relationship Quality	0.957	11.542	0.000*	Accepted
Satisfaction	←	Relationship Quality	0.855	11.440	0.000*	Accepted

* Significant at 1 Percent.

DISCUSSION

This study's primary purpose was to assess the quality in geriatric healthcare delivery and thereby draw a hypothetically based and empirically tested relationship between elderly healthcare delivery dimensions. The evaluations on the services received will determine the relationship quality construct from elderly's point of view. The study received high average variable scores that might be due to the improvements in public healthcare infrastructure and the resulted quality in service delivery and the higher quality standards in the private facilities due to the increased competition.

This study shows that inclusion of relationship quality aspects into the healthcare design will bring positive results as the outcome of care and relationship between the caregivers and the patients is coherent. It is evident that service quality in elderly healthcare delivery leads to trust and satisfaction. The developed model shows that service quality with all its tangibility, reliability, assurance, and empathy dimensions leads to relationship quality. The findings are in line with the previous study results [10,15-17] and validates the previous study that satisfaction depends on both patient as well as situation-related facets.[18] Similarly, Lee et al. [19] found that patients' value 'physicians' care more than any other situational attribute. This finding is highly significant when the elderly expects a good relationship quality level from the health care setting and will transform their perceptions into continued doctor consultation, eventually, become a significant determinant of healthcare-seeking behaviour.

The study is substantial as per the finding of Huang et al. [20], that the relationships among satisfaction, patient centricity, trust, and service quality in a post-treatment scenario become significant as it contributes to a profound understanding of the relationship between the physician and patient. The study shows that an improvement in service quality contributes significantly to enhancing relationship quality, while patient-centricity does not contribute to relationship quality, though it has a direct relationship with service quality. According to Herzberg's two-factor motivation theory, satisfaction and dissatisfaction are produced by various factors where specific predictors create satisfaction, while the absence of these predictors may not dissatisfy them.[21] The study findings confirm Herzberg's theory that patient-centricity affects service quality even when it does not contribute to relationship quality. The absence of patient centricity will

negatively impact service quality perception of the elderly, affecting their relationship quality perception. However, this finding is incongruent with the previous finding. [22]

Despite having an excellent average score for satisfaction and patient centricity, the absence of a hypothetical relationship between them may be explained that the elderly expects personal care and hence, affective reactions from the healthcare providers are equal or more vital than the cognitive reactions and the healthcare outcomes. Coyle & Williams [23] found that dissatisfaction results in a dehumanized, objectified, disempowered, and devalued situation. Similarly, Avis et al. [24] found that, in healthcare delivery, satisfaction may not be so pertinent based on the outcome, predominantly, in contexts where patients get to know about "bad news" or to adjust to debilitating health conditions, but often stay positive on the way they get care. This is consistent with the finding of Dawson et al. [25], who conducted a study among cancer patients, that the majority of them were satisfied with the treatments, though they knew the severity of their disease..

This study supports the findings of Sofaer & Firminger [26], who summarized the seven essential dimensions of healthcare, which are particularly overarching the variables of service quality and patient centricity. Further, the developed model confirms Donabedian's Structure-Process-Outcome (SPO) model [27], where the structure and process aspects of the theory underpins the service quality and patient centricity constructs of the present study, consequently leading to the outcome construct, relationship quality. This model further confirms the Kano model, that minimum quality expectations of patients such as physicians' high-quality communication are taken for granted and lead to dissatisfaction if not satisfied, yet they may not create satisfaction, even though it is present.

There has been a growth in the number of healthcare facilities, both in Kerala's public and private healthcare industry. It is a misconception that the number of healthcare facilities contributes to effective healthcare delivery and results in affective consequences such as satisfaction, trust, and service quality. In the extremely competitive healthcare industry, a sustainable establishment will ensure a close physician-patient bond, provide better medical treatment-related services, and strengthen patient outcomes.[20] In a situation when Non-Communicable Diseases (NCDs) and infectious diseases converge and become a significant threat for the elderly population in Kerala [28], improving the quality of

healthcare delivery based on relationship must be prioritized.

Positioning a healthcare system around patients' needs and preferences will increase satisfaction and their consequent health outcomes and perhaps contribute to efficiency enhancement of any healthcare management system.[29] A healthcare system's sustainability mainly depends on patient experience. [30] Hence, to create and sustain a competitive advantage in geriatric healthcare delivery, the variables in the present model are significant and will positively address the need for quality healthcare access demand.

This research is a pioneer and novel diagnostic tool that identified the determinants of relationship quality in geriatric care. The outcome of this study will give insights to the stakeholders, including healthcare providers and policymakers in implementing effective geriatric healthcare delivery and will enable them to analyse the functional efficiency, competitiveness, and quality improvement in geriatric care. The model developed from the study can apply to any other healthcare scenario by adjusting the relevant variables. The study has reproducibility and makes a meaningful contribution to the health management literature in terms of empirical knowledge.

The study has its limitations. First, this study was conducted in Kerala, and therefore, the results may not be suitable in an international context. Second, this study has been carried out among the elderly regardless of their choice of the type of healthcare facilities. Third, the survey was carried out during COVID-19 pandemic, which might have affected their responses. Future research has scope in a larger context, including public, private, tertiary, secondary, or primary healthcare settings.

CONCLUSION

This study proposes a model of relationship quality in geriatric healthcare delivery based on relationships among service quality, patient centricity, trust, and patient satisfaction. Between the two cognitive constructs, service quality, and patient centricity, the former has emerged as a significant determinant of relationship quality. The elderly perceived relationship quality as a significant concern while accessing healthcare, and therefore healthcare organizations should consider the construct diligently.

Being one of the major determinants of health-seeking behaviour, relationship quality must be integral to geriatric care management system in a progressed society like Kerala.

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